Department of LABOR AND INDUSTRIES

Published by
Health Services Analysis Section
Olympia, WA 98504-4322

PROVIDER BULLETIN

PB 99-04

THIS ISSUE

Physician Assistant Provider Numbers

TO:
Certified Physician Assistants
Advanced Registered Nurse Practioners
Clinics
Emergency Room Physicians
Hospitals
Medical Physicians
Osteopathic Physicians
Self-Insured Employers

CONTACTS:
Evonne Peryea
Health Services Analysis
PO Box 44322
Olympia WA 98504-4322

(360) 902-6828
(360) 902-4249 FAX

For billing questions contact:
Provider Toll Free
1-800-848-0811
902-6500 in Olympia

Purpose

This Provider Bulletin pertains to State Fund claims only. It announces changes on how certified physician assistants (PAs) must submit bills to the department for health care services. Effective August 1, 1999 all certified physician assistants who treat industrially injured or ill workers must have their own provider number. There are no changes in the level of reimbursement or department payment policies. **Please circulate this bulletin to all staff and departments that are involved with physician assistant services and billing.**

What has changed regarding how physician assistants must bill the Department?

For dates of service on or after August 1, 1999, physician assistants must use their own provider number on all bills submitted to the department when they personally perform the service. This change is consistent with Washington Administrative Code (WAC) 296-20-015, which requires providers who treat industrially injured or ill workers to obtain and use a provider number when billing for services they perform.

In addition to requiring individual PA provider numbers, the use of modifiers will change**. For dates of service on or after August 1, 1999, the department will no longer accept the following modifiers:**

Modifiers

-AU	For other than assistant at surgery, in an office setting
-AN	For other than assistant at surgery, in a hospital setting
-AS	For assistant at surgery

Instead of the above modifiers, PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of the department's *Medical Aid Rules and Fees Schedules.* For example, to bill for Assistant at Surgery, the PA would use modifier 80, 81, or 82, as appropriate.

Please note, the following department policies and/or rules have <u>not</u> changed:

Supervising or consulting physicians must still sign Reports of Accident and Reopening Applications as well as forms or letters relating to time loss or vocational services. (See physician responsibilities outlined in RCW 51.28.020, RCW 51.48.060 & RCW 51.32.090.)

For the time being, WAC 296-20-01501 and WAC 296-20-12501, which apply to physician assistants remain in effect. In the future, the department plans to correct the physician assistant title in WAC, from the term "Physician's Assistant" to the correct title, "Physician Assistant." The department also plans to update the billing instruction language in WAC 296-20-12501. Interested persons will be notified of the rule making process**. In the meantime, PAs should follow the billing instructions stated in this Provider Bulletin and in the department's billing instructions.**

What must physician assistants do if they do not have a Labor and Industries performing provider number?

If you have not applied for, or received a provider number, contact the department's Provider Accounts Section **immediately** at the address below:

Department of Labor and Industries
Provider Accounts Section
PO Box 44261
Olympia, WA. 98504-4261

Also, physician assistants must notify the department if their employer's tax reporting number changes. This change could be the result of a change in employment, being assigned a new supervising physician, or a change in the employer's tax number. You can notify the department of these changes by calling Provider Accounts at (360) 902-6605, (360) 902-6543, (360) 902-5307 or (360) 902-6545. Physician assistants who work under several physicians or clinics which have different employer tax numbers are required to have a separate provider number for each employer.

When did the department first notify physician assistants that they needed to apply for a provider number?

The department sent a letter in March, 1999 along with a provider application to all licensed physician assistants in Washington, Oregon and Idaho. The department requested they either apply for a provider number or advise the department if they did not plan to treat industrially injured or ill workers.

For physician assistants who applied and were found eligible, the department followed up with a letter notifying physician assistants of their newly assigned provider numbers along with Billing Instructions to help them submit their bills correctly. This information was sent to providers in May and June 1999.

Are there any changes to how physician assistants submit bills to the department?

HCFA-1500 forms:

See the attached example of a HCFA-1500 form which details how this bill form is filled out. Please note: Beginning **August 1, 1999**, PAs must fill in their name and provider number in Box 33 of the HCFA-1500 bill form.

Electronic bills:

Beginning **August 1, 1999**, you must place your physician assistant provider number in the performing provider field in your particular electronic billing format.

Physician assistants billing directly under the physician and the physician is the payee:

The supervising physician's provider number is placed in the Billing Provider Number Field of the format

and the physician assistant's provider number is placed in the Performing Provider Number Field of the format.

Physician assistants billing as part of a group and the group is the payee: The group provider number is placed in the Billing Provider Number Field and the physician assistant's provider number is placed in the Performing Provider Number Field.

This will affect the following formats:

Electronic Medical Claims HCFA Format

RECORD C1 - Field 9	Billing Provider Number
RECORD T1 - Field 11	Performing Provider Number

Medical Tape Format

Record HM - Field 6	Billing Provider Number
Record DM - Field 11	Performing Provider Number

Providers billing through a billing intermediary: Please contact your billing intermediary if you are unsure where to place the supervising physician's provider number, the physician assistant's provider number or the group provider number, whichever is applicable.

If you have any questions regarding the use of these fields, please refer to your electronic billing format information, or contact the department's Electronic Billing Unit at (360) 902-6511 or (360) 902-6512.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

L & I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

CARRIER

☐☐☐ PICA — *PLEASE PRINT OR TYPE* — **EXAMPLE: PHYSICIAN ASSISTANT** — PICA ☐☐☐

PATIENT AND INSURED INFORMATION

L & I ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **000 - 00 - 0000**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Smith, Connie**	3. PATIENT'S BIRTH DATE MM DD YY: **01 01 45** SEX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **151 Oak Creek Lane**	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: **Morton** STATE: **WA**	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE: **98519** TELEPHONE (Include Area Code): **(360) 000 - 0000**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: **X000000**
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME: **ABC Company Inc**
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY **01 31 98** ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **Xxxxx Xxxxx MD**	17a. I.D. NUMBER OF REFERRING PHYSICIAN: **0000000**	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE MM DD YY / MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **09 01 98 / 09 01 98**	**3**	**3**	**99202** / **E&M Visit**	**847**	**xx xx**	**1**				
2 **09 01 98 / 09 01 98**	**3**	**3**	**22630** / **51 Lumbar Spine**	**847**	**xxxx xx**	**1**				
3 **09 01 98 / 09 01 98**	**3**	**3**	**22214** / **80 Rev Lumbar**	**847**	**xxxx xx**	**1**				
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00 - 0000000 ☐ ☒	**Optional**	☐ YES ☐ NO	$ **xxxx xx**	$	$

31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS - (I certify that I understand L & I living instructions, that information contained on the bill is consistent with those instructions and accurate to the best of my knowledge.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED DATE		**Xxxxx Xxxxx, PA** **PO Box 779** **Morton, WA 98519 (360)000-0000** PIN # **0000000** GRP# **0000000**

PA's L&I Provider Account #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
F245-127-000 (3/92)

FORM HCFA-1500 (12-90)
FORM OCP-1500 FORM RRB-1500